		FOR OHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044487

Facility Name: Greenbrier Lodge

Address: 600 South Maple (Number) Piper City (City) 60959 (Zip Code)

County: Iroquois

Telephone Number: 815-686-2277 **Fax #** 815-686-2812

IDPA ID Number: 370920203

Date of Initial License for Current Owners: 06/01/2001

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		x	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Teresa Thompson **Telephone Number:** 815-686-2277

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 11/01/2004 to 10/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Teresa Thompson, RN
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Michael Stroud, Smith, Koelling, Dykstra & Ohm, P.C.
(Firm Name & Address) 1605 N. Convent, Bourbonnais, IL 60914
(Telephone) 815-937-1997 Fax # 815-935-0360

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2004 Ending: 10/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,546	637	2,867	5,050	8
9	SNF/PED					9
10	ICF	8,994	4,873	1	13,868	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,540	5,510	2,868	18,918	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.38%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 06/01/2001

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 60 and days of care provided 2,868

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 10/31/2005 Fiscal Year: 10/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Greenbrier Lodge # 0044487 **Report Period Beginning:** 11/01/2004 **Ending:** 10/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	126,529	19,633	6,882	153,044		153,044	(824)	152,220			1
2	Food Purchase		124,239		124,239		124,239	(12,113)	112,126			2
3	Housekeeping	91,688	9,794		101,482		101,482	(720)	100,762			3
4	Laundry	31,074	14,914		45,988		45,988		45,988			4
5	Heat and Other Utilities			75,772	75,772		75,772	(20,293)	55,479			5
6	Maintenance	47,533	17,385	23,183	88,101		88,101	(636)	87,465			6
7	Other (specify):*			2,220	2,220		2,220	(2,220)				7
8	**TOTAL General Services**	296,824	185,965	108,057	590,846		590,846	(36,806)	554,040			8
	B. Health Care and Programs											
9	Medical Director			2,000	2,000		2,000		2,000			9
10	Nursing and Medical Records	964,635	61,398	1,864	1,027,897		1,027,897		1,027,897			10
10a	Therapy		22	182,418	182,440		182,440		182,440			10a
11	Activities	40,031	1,345	2,318	43,694		43,694		43,694			11
12	Social Services	66,731	101	3,043	69,875		69,875		69,875			12
13	CNA Training											13
14	Program Transportation			10,601	10,601	(6,827)	3,774		3,774			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,071,397	62,866	202,244	1,336,507	(6,827)	1,329,680		1,329,680			16
	C. General Administration											
17	Administrative	69,142			69,142		69,142		69,142			17
18	Directors Fees			12,000	12,000		12,000		12,000			18
19	Professional Services			24,827	24,827		24,827		24,827			19
20	Dues, Fees, Subscriptions & Promotions			16,881	16,881		16,881	(8,062)	8,819			20
21	Clerical & General Office Expenses	50,942	9,336	41,197	101,475		101,475		101,475			21
22	Employee Benefits & Payroll Taxes			396,477	396,477		396,477		396,477			22
23	Inservice Training & Education			1,448	1,448		1,448		1,448			23
24	Travel and Seminar			2,357	2,357		2,357		2,357			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			66,911	66,911		66,911		66,911			26
27	Other (specify):*											27
28	**TOTAL General Administration**	120,084	9,336	562,098	691,518		691,518	(8,062)	683,456			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,488,305	258,167	872,399	2,618,871	(6,827)	2,612,044	(44,868)	2,567,176			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Greenbrier Lodge #0044487 **Report Period Beginning:** 11/01/2004 **Ending:** 10/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			68,570	68,570		68,570	(24,884)	43,686			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,774	7,774		7,774	(3,529)	4,245			32
33	Real Estate Taxes			50,276	50,276		50,276	(15,034)	35,242			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,281	2,281		2,281		2,281			35
36	Other (specify):*											36
37	**TOTAL Ownership**			128,901	128,901		128,901	(43,447)	85,454			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					6,827	6,827		6,827			38
39	Ancillary Service Centers		13,197	92,128	105,325		105,325		105,325			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,850	32,850		32,850		32,850			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		13,197	124,978	138,175	6,827	145,002		145,002			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,488,305	271,364	1,126,278	2,885,947		2,885,947	(88,315)	2,797,632			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2004 Ending: 10/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,565)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,338	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,765)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(85,323)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (88,315)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (88,315)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	x		$ 6,827	14	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 6,827		47

STATE OF ILLINOIS

Greenbrier Lodge

ID# **0044487**

Report Period Beginning: **11/01/2004**

Ending: **10/31/2005**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Apartment - Dietary Supplies	$ (824)	1	1
2	Apartment - Food Cost	(12,113)	2	2
3	Apartment - Housekeeping Supplies	(720)	3	3
4	Apartment - Utilities	(15,728)	5	4
5				5
6	Apartment - Repairs/Maintenance	(636)	6	6
7	Apartment - Lifeline	(2,220)	7	7
8	Apartment - Advertising	(2,297)	20	8
9	Apartment - Mortgage Interest	(3,529)	32	9
10	Apartment - Real Estate Tax	(15,034)	33	10
11	Apartment - Depreciation	(32,222)	30	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(85,323)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenbrier Lodge # 0044487 **Report Period Beginning:** 11/01/2004 **Ending:** 10/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(824)	0	0	0	0	0	0	0	0	0	0	(824)	1
2	Food Purchase	(12,113)	0	0	0	0	0	0	0	0	0	0	(12,113)	2
3	Housekeeping	(720)	0	0	0	0	0	0	0	0	0	0	(720)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(20,293)	0	0	0	0	0	0	0	0	0	0	(20,293)	5
6	Maintenance	(636)	0	0	0	0	0	0	0	0	0	0	(636)	6
7	Other (specify):*	(2,220)	0	0	0	0	0	0	0	0	0	0	(2,220)	7
8	**TOTAL General Services**	(36,806)	0	0	0	0	0	0	0	0	0	0	(36,806)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(8,062)	0	0	0	0	0	0	0	0	0	0	(8,062)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(8,062)	0	0	0	0	0	0	0	0	0	0	(8,062)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(44,868)	0	0	0	0	0	0	0	0	0	0	(44,868)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Greenbrier Lodge** **#** **0044487** **Report Period Beginning:** **11/01/2004** **Ending:** **10/31/2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(24,884)	0	0	0	0	0	0	0	0	0	0	(24,884)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,529)	0	0	0	0	0	0	0	0	0	0	(3,529)	32
33	Real Estate Taxes	(15,034)	0	0	0	0	0	0	0	0	0	0	(15,034)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(43,447)	0	0	0	0	0	0	0	0	0	0	(43,447)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(88,315)	0	0	0	0	0	0	0	0	0	0	(88,315)	45

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2004 Ending: 10/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Greenbrier Lodge, Inc.
Attachment to Schedule VII - Related Parties
10/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional s

1 OWNERS			Directors Fees, Line 18		
Name	Ownership %				
Margery Arends	$4,000	7.41%			
Della M Bork, Trustee	2,000	3.70%			
Harold F Bork Estate	2,000	3.70%			
Ronald D Bork	4,000	7.41%	600		
Mary K Brown, Trustee	2,000	3.70%			
Betty Cook	2,000	3.70%			
Eugene Doran	2,000	3.70%			
Shirley Freeman	2,000	3.70%			
Robert Frerichs	4,000	7.41%			
Ray Froelich	2,000	3.70%			
Ruth Hanna	2,000	3.70%			
Charles Kerchenfaut	2,000	3.70%			
Marilyn Kerchenfaut	2,000	3.70%	2,400		
Robert Kurtenbach	4,000	7.41%			
Dr Hugh McIntosh Trust	2,000	3.70%			
Gladys McMillan Estate	2,000	3.70%			
Darla Propes	2,000	3.70%			
Jerome Rebholz	2,000	3.70%	2,100		
Johanna C. Somers, Trustee	4,000	7.41%	2,400		
Edith Stuckey	2,000	3.70%			
James D Stuckey	4,000	7.41%	600		
Robert King	0	0.00%	600		
Janet Livengood	0	0.00%	600		
Jeff McMillan	0	0.00%	600		
Jeff Orr	0	0.00%	2,100		
	$ 54,000	100.00%	12,000	0	0

schedule if necessary.

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2004 Ending: 10/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	See schedule of owners for directors fees								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2004 Ending: 0/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2004 Ending: 10/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Vermillion Valley Bank		x	Working Capital	$955.00	06/02/2005	150,000	154,245	06/02/2006	0.0675	4,245	6
7												7
8												8
9	TOTAL Facility Related				$955.00		$ 150,000	$ 154,245			$ 4,245	9
	B. Non-Facility Related*											
10	Vermillion Valley Bank		x	Apartment Mortgage	$2,509.96	07/21/2003	137,286	49,974	10/09/08		3,529	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$2,509.96		$ 137,286	$ 49,974			$ 3,529	14
15	TOTALS (line 9+line14)						$ 287,286	$ 204,219			$ 7,774	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ None** **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Greenbrier Lodge **#** 0044487 **Report Period Beginning:** 11/01/2004 **Ending:** 10/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	29,361	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	35,238	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,877	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	29,365	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	35,242	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	35,331	8
2001	35,376	9
2002	35,170	10
2003	35,284	11
2004	35,238	12

Tax paid in 2005 for 2004 = 35,238 (difference to 2005 immaterial)

35,238/12 months x 10 months accrual (through 10/31/05) = 29,365

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenbrier Lodge COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0044487

CONTACT PERSON REGARDING THIS REPORT Teresa Thompson

TELEPHONE 815-686-2277 FAX #: 815-686-2812

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-04-03-300-003	Nursing Home	$ 35,238.00	$ 35,238.00
2.	04-04-03-302-001	Apartments	$ 15,093.00	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.	Real esate taxes are billed sepertely		$	$
8.	for the Nursing Home and the		$	$
9.	apartments. Therefore, no cost		$	$
10.	allocation is required		$	$
		TOTALS	$ 50,331.00	$ 35,238.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? x YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2004 Ending: 10/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,804 B. General Construction Type: Exterior Brick Frame Protected Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Facility	228,690	1972	$ 22,181	1
2					2
3	TOTALS	228,690		$ 22,181	3

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2004 Ending: 10/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1972	1972	$ 519,786	$ 14,851	35	$ 14,851	$	$ 486,357	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fully Depreciated				44,845					44,845	9
10											10
11	Building Imiprovements			1995	78,510	2,013	39	2,013		20,718	11
12	Land Improvements			1995	21,490	1,319	15	1,433	114	14,427	12
13	Septic System			1997	18,954	1,168	15	1,264	96	10,109	13
14	Drainage Improvement			1998	5,561	333	15	371	38	2,719	14
15	Sprinkler System			1998	14,144	514	27.5	514		3,772	15
16	Landscaping			1999	19,119	1,187	15	1,275	88	7,481	16
17	Floor Tiling			1997	3,255	201	15	217	16	1,772	17
18	Wall Protectors			2002	3,730	533	15	249	(284)	933	18
19	Fire Door			2004	1,702	44	39	44		80	19
20	Aluminum Roof Coating			2004	4,485	115	39	115		134	20
21	Air Handlers			2005	2,656	5	39	6	1	6	21
22	Sidewalk			2005	1,440	6	20	8	2	8	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2004 Ending: 10/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 739,677	$ 22,289		$ 22,360	$ 71	$ 593,361	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2004 Ending: 10/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 101,499	$ 8,126	$ 15,411	$ 7,285		$ 77,254	71
72	Current Year Purchases	8,206	383	365	(18)		365	72
73	Fully Depreciated Assets	91,604					91,604	73
74								74
75	TOTALS	$ 201,309	$ 8,509	$ 15,776	$ 7,267		$ 169,223	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	1999 Dodge Van	2001	$ 27,750	$ 5,550	$ 5,550	$	5	$ 21,274	76
77										77
78										78
79										79
80	TOTALS			$ 27,750	$ 5,550	$ 5,550	$		$ 21,274	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 990,917	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 36,348	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 43,686	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,338	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 783,858	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment Building & Equipment	$ 834,522	$ 32,222	$ 281,720	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 834,522	$ 32,222	$ 281,720	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2004 Ending: 10/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2004 Ending: 10/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts	66,315					66,315	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39.3							25,813	13
14	TOTAL			$ 66,315		$	$		$ 92,128	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Greenbrier Lodge # 0044487 **Report Period Beginning:** 11/01/2004 **Ending:** 10/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 10/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 152,457	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	60,539		7
8	Accounts Receivable (owners or related parties)	539,141		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 752,137	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,181		13
14	Buildings, at Historical Cost	1,458,624		14
15	Leasehold Improvements, at Historical Cost	345,143		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(1,070,987)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 754,961	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,507,098	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 127,635	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	154,245		29
30	Accrued Salaries Payable	65,169		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,942		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Accrued Expenses	4,314		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 393,305	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	49,973		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 49,973	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 443,278	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,063,820	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,507,098	$	48

***(See instructions.)**

Facility Name & ID Number Greenbrier Lodge **#** 0044487 **Report Period Beginning:** 11/01/2004 **Ending:** 10/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,104,686	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,104,686	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(27,366)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(13,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (40,866)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,063,820	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2004 Ending: 10/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,598,493	1
2	Discounts and Allowances for all Levels	(500,397)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,098,096	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	372,499	6
7	Oxygen	8,478	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 380,977	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	134,640	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,767	19
20	Radiology and X-Ray		20
21	Other Medical Services	18,322	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 166,729	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	936	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 936	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Apartment Rents	188,217	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 188,217	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,834,955	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	590,846	31
32	Health Care	1,334,192	32
33	General Administration	693,833	33
	B. Capital Expense		
34	Ownership	128,901	34
	C. Ancillary Expense		
35	Special Cost Centers	105,325	35
36	Provider Participation Fee	32,850	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,885,947	40
41	**Income before Income Taxes (line 30 minus line 40)****	(50,992)	41
42	**Income Taxes**	23,626	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (27,366)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2004 Ending: 10/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,865	4,254	$ 108,060	$ 25.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,289	6,922	134,912	19.49	3
4	Licensed Practical Nurses	9,267	10,200	190,903	18.72	4
5	CNAs & Orderlies	38,540	42,421	459,833	10.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,812	1,994	21,108	10.59	9
10	Activity Assistants	2,636	2,901	22,935	7.91	10
11	Social Service Workers	5,579	6,141	71,465	11.64	11
12	Dietician	1,751	1,927	20,241	10.50	12
13	Food Service Supervisor					13
14	Head Cook	7,376	8,119	65,180	8.03	14
15	Cook Helpers/Assistants	6,855	7,545	52,821	7.00	15
16	Dishwashers					16
17	Maintenance Workers	4,183	4,604	51,808	11.25	17
18	Housekeepers	11,283	12,419	99,236	7.99	18
19	Laundry	4,428	4,874	35,360	7.25	19
20	Administrator	1,888	2,078	74,482	35.84	20
21	Assistant Administrator					21
22	Other Administrative	3,891	4,283	58,166	13.58	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	1,850	2,036	21,795	10.70	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	111,493	122,718	$ 1,488,305 *	$ 12.13	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2004 Ending: 10/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Teresa Thompson	Administrator	0	$ 69,142
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 69,142

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
		$
Smith, Koelling Dystra & Ohm	Accounting Services	20,165
Richard Peelo & Assoc	Cost Report	4,200
Amy Aquino	Legal	462
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 24,827

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,921
Unemployment Compensation Insurance	34,591
FICA Taxes	110,083
Employee Health Insurance	166,845
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Incentives	8,037
TOTAL (agree to Schedule V, line 22, col.8)	$ 396,477

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,515
Health Care Worker Background Check	208
(Indicate # of checks performed 13)	
Public Relations Expense	5,765
Advertising	2,297
Professional Dues & Licenses	5,106
Less: Public Relations Expense	(5,765)
Non-allowable advertising	(2,297)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,819

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	263
Seminar Expense	2,094
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,357

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Greenbrier Lodge **#** 0044487 **Report Period Beginning:** 11/01/2004 **Ending:** 10/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,458** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **32,850**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2004 Ending: 10/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Greenbrier Lodge
004487
10/31/2005

Attachment to Page 23, Question 14

The apartments are housed in a totally separate building with all related expenses classified separately in the chart of accounts

Greenbrier Lodge, Inc
Period ended 10/31/2005
ID #0044487

Attachment to Schedule XIV, Line 13

Description	Amount
IV Therapy Supplies	1940
Air Fluidized Therapy/Oxygen	15782
Contracted Lab	7233
Oxygen Supplies	690
Other	168
	25813

Greenbrier Lodge, Inc
44487
10/31/2005

Attachment to Schedule V, Line 13

Date	Attendee	Job Title	Amount	Location	Seminar Title	Seminar Sponsor
9/30/2005	Terri Thompson	Administrator	176.58	Springfield, IL	IHCA Convention	IHCA
4/30/2005	Terri Thompson	Administrator	33.85	Springfield, IL	Health Care	IHCA
9/30/2005	Amy Aquino Michelle Clifton	DON ADON	74.80	Peoria, IL	Health Care	IHCA
11/15/2004	Matt Kennedy Sharon Bargmann	Accountant Social Services	90.00	Tinley Park, IL	Medicare Part A Essentials	Administar A
6/30/2005	Terri Thompson	Administrator	100.00	Springfield	Quality Healthcare Nursing Homes	IFQHC
8/30/2005	Terri Thompson	Administrator	1,045.00	Springfield	Life Safety Code & Surveys	IHCA
3/15/2005	Terri Thompson Amy Aquino Michelle Clifton Sharon Bargman Cyra Walls	Administrator DON ADON Social Service Activity Director	287.05	Springfield	Annual Convention	IHCA
7/19/2005	Matt Kennedy Sharon Bargman Michelle Clifton Nancy Carpenter Terri Thompson	Accounting Social Services ADON Medical Records Administrator	99.00	Teleconference	New SNF Requirements	Polaris
	Dawn Siwinski	Dietary Management	450.00	Self Study	Dietary Management	University of ND
			2,356.28			